Delivering coronial services

Report 6: 2018–19

Queensland Audit Office
Better public services

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Your ref:
Our ref: 9177P

18 October 2018

The Honourable C Pitt MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

Dear Speaker

Report to parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled Delivering coronial services (Report 6: 2018–19).

In accordance with s.67 of the Act, would you please arrange for the report to be tabled in the Legislative Assembly.

Yours sincerely

Brendan Worrall
Auditor-General

Contents

Audit objective and scope

In this audit, we assessed whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths. We examined whether agencies:

- provide adequate support to bereaved families
- have efficient and effective processes and systems for delivering coronial services
- plan effectively to deliver sustainable coronial services.

The scope of the audit included three public sector agencies who have specific roles but are collectively responsible for providing coronial services:

- Department of Justice and Attorney-General
- Department of Health
- Queensland Police Service.

Although not subject to this audit, we consulted with the Queensland State Coroner, Deputy-State Coroner and all other coroners and the Department of the Premier and Cabinet. The audit identified learnings and made recommendations that are relevant to whole of government.

Appendix B contains further details about the audit scope and our methods.

Reference to comments

In accordance with s. 64 of the *Auditor-General Act 2009*, we provided a copy of this report to relevant agencies. In reaching our conclusions, we considered their views and represented them to the extent we deemed relevant and warranted. Any formal responses from the agencies are at Appendix A.

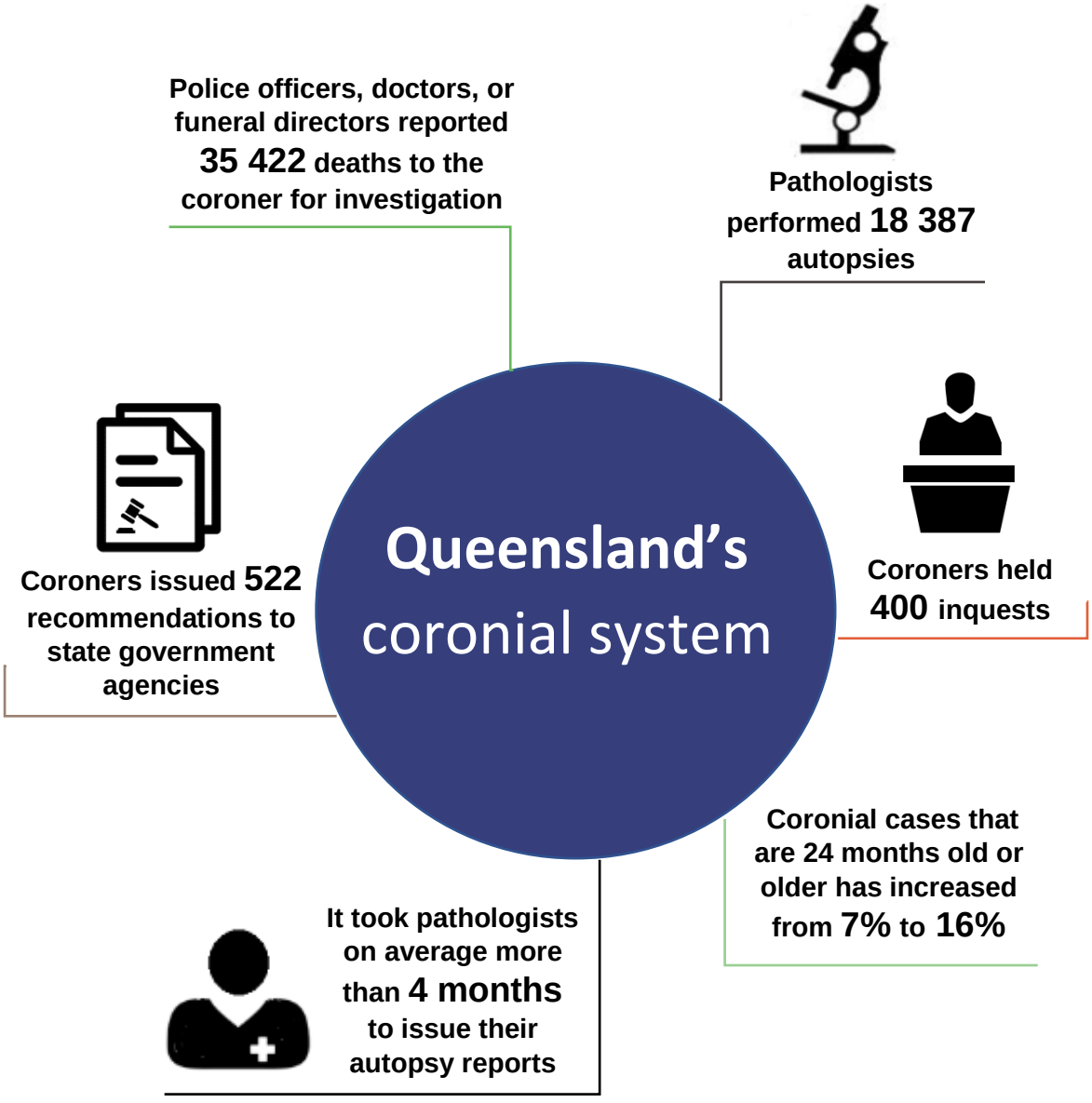
Glossary

Term	Definitions
Anatomical pathologists	According to the Royal College of Pathologists of Australasia anatomical pathologists are highly trained medical doctors who look at organs and tissues to determine the causes and effects of particular diseases.
Autopsy	This is the examination and dissection of a body after death for determination of the cause and circumstances of death. Also called a post-mortem examination.
Clearance rate	The clearance rate measures the number of coronial cases finalised by the Coroners Court of Queensland in a reporting period by the number reported (lodged) in the same period.
Conveyance	In the context of this report, this is the action or process of transporting a body from one place to another.
Coroner	According to the *Coroners Act 2003, Division 4, Section 82 (1),* a coroner is a magistrate who is responsible for investigating reportable deaths.
Coronial case	In the context of this report, a coronial case is an investigation into a death reported to the Coroners Court of Queensland.
Coroners Court	The Coroners Court is a court of record established under Part 4 Division 1 of the *Coroners Act 2003,* where coroners investigate, hear evidence and deliver findings about the causes and circumstances of reportable deaths.
Coroners Court of Queensland	This unit of the Department of Justice and Attorney-General supports the state coroner in administering and managing a coordinated state-wide coronial system in Queensland. It provides a central point of contact and publicly accessible information to families and the community about coronial matters.
Forensic medical officer	The Clinical Forensic Medicine Unit within the Department of Health employs forensic medical officers to provide expert clinical and medico-legal opinions in court and advice in healthcare-related death investigations.
Forensic Odontology	According to the Australian Medical Association forensic odontology is a discipline that involves the application of dental specific knowledge to legal and criminal issues. It primarily focuses on human identification, disaster victim identification, age assessment and examination of bite marks.
Forensic pathologist	According to the Royal College of Pathologists of Australasia, a forensic pathologist is a medical specialist with autopsy expertise who performs coronial autopsies and related tasks, forming opinions about causes and circumstances of death.
Histology	According to Black's Medical Dictionary, histology is the study of minute structure of tissues. Pathologists use a microscope to study tissue on a slide.

Term	Definitions
Inquest	An inquest is a court hearing conducted by a coroner to gather information about the cause and circumstances of a death. An inquest isn't a trial and there is no jury. It is not about deciding whether a person is guilty of an offence or civilly liable. Under the *Coroners Act 2003,* there are provisions that mandate when a coroner must hold an inquest, such as a death in custody.
Organ retention	According to the Royal College of Pathologists Australasia organs may be retained at autopsy for diagnosis and for other purposes. Under section 24 of the *Coroners Act 2003,* organs are defined as prescribed tissue which may only be retained if the coroner is satisfied that it is necessary, and the family has been appropriately consulted.
Forensic Neuropathology	Forensic neuropathology is concerned with the diagnosis of injury and disease of the brain, spinal cord, muscles and peripheral nerves in coroners' autopsies.
Registrar	The coroners are supported by a coronial registrar located in Brisbane. The registrar is responsible for determining whether a death referred to a coroner is reportable (see below) and authorising the issue of a death certificate for reportable deaths.
Reported death	In the context of this report, a death reported to the Coroner's Court of Queensland that may or may not be reportable under the *Coroners Act 2003.*
Reportable death	According to the *Coroners Act 2003, Part 2, Section 8(3),* a death is reportable if it occurred in Queensland and meets one or more of the criteria below: • it is not known who the deceased person is • it was a violent or otherwise unnatural death • the death happened in suspicious circumstances • it was a healthcare-related death • a cause of death certificate has not been issued and is not likely to be issued • it was a death in care or in custody • the death happened in the course of or as a result of police operations.
Royal College of Pathologists Australasia	This is a medical organisation that promotes the science and practice of pathology in Australasia. Their mission is to train and support pathologists and improve the use of pathology testing.
Triage	Triage means sorting coronial cases into categories (such as reportable and non-reportable deaths) that reflect whether an investigation is required, and the extent of autopsy needed (for example, external examination, partial autopsy, or full internal autopsy).

Key facts

Between 2011–12 and 2017–18:



Notes: The coronial statistics displayed above are based on data extracted from the Coroners Court of Queensland's case management system on 21 June 2018 and may not capture all deaths reported to the Coroners Court of Queensland in 2017–18. The forensic pathology statistics are based on data extracted from the Forensic and Scientific Services Auslab database on 17 July 2018 and include all autopsies performed between 2011–12 and 2017–18.

Source: Queensland Audit Office, using data provided by the Department of Justice and Attorney-General's Coroners Court of Queensland and data provided by the Department of Health's Forensic and Scientific Services.

Introduction

The *Coroners Act 2003* (the Act) governs Queensland's coronial system. It requires coroners to investigate the circumstances of a reportable death and provides the broad criteria of the types of deaths which are reportable. This includes violent or unnatural deaths, deaths in custody and healthcare-related deaths (see glossary for more information on reportable deaths). For cases that proceed to inquest, coroners may make recommendations intended to prevent deaths from happening in similar circumstances in the future.

The Act recognises the needs and concerns of the family of the deceased. An effective and efficient coronial system will enable a coroner to provide timely and reliable answers to the family about their loved one's death. Noting the importance of an independent and robust investigation, it will also consider their views and provide adequate and timely information to them throughout coronial investigations.

Queensland's coronial system is complex, and coroners rely on the timely and reliable services of multiple public sector and contracted agencies across a geographically dispersed state.

The Department of Justice and Attorney-General (through its Coroners Court of Queensland), the Department of Health (through its Forensic and Scientific Services), and the Queensland Police Service are the public sector agencies responsible for supporting coroners.

Each agency plays a key role across the coronial process:

- The Coroners Court of Queensland provides legal and administrative support to coroners and the registrar.
- Forensic and Scientific Services provide clinical, advisory, scientific, counselling, and forensic pathology services, including autopsies.
- The Queensland Police Service provides investigative support and specialised forensic analysis.

Summary of audit findings

Supporting coroners

Structure, leadership, and accountability

The Coroners Court of Queensland, Forensic and Scientific Services, and the Queensland Police Service (the agencies) each play a key role in supporting coroners. However, none is accountable for managing Queensland's coronial system or coordinating the various activities across the system. Under the Act, the Queensland State Coroner (the state coroner) is legally accountable for the efficiency of Queensland's coronial system, but the role has little functional control over the resources needed to effectively fulfil this responsibility.

This void has resulted in a system that is under-resourced to meet existing and future demand. This is most acute in forensic pathology services. In March 2015, the state coroner raised concerns about the future sustainability of forensic pathology services, stating that '… the situation is fast becoming a critical vulnerability for Queensland's coronial system'. He also raised concerns about triaging practices and suggested amendments to the Act.

The agencies made some improvements to triage practices but not amendments to the Act. It also took the agencies more than two years to establish a multi-agency project reference group to identify and consider potential models for forensic pathology services. In July 2018, the project reference group recommended incrementally centralising forensic pathology services in Brisbane. However, the submission by the project reference group lacked robust assessment of the options and the merits of the recommended model.

The coronial system relies on the dedication of staff and agencies cooperate as best they can to support coroners in finalising their investigations with the resources they have. However, without adequate leadership, clearly defined accountabilities, and with demand increasing, their support is at times ineffective. As expected, agencies focus on the services they're responsible for delivering within the context of multiple competing priorities. This sometimes means they don't adequately consider the overall system effectiveness, coroners, and bereaved families.

For the three agencies delivering coronial services it is one of many functions they perform and is not necessarily considered their core business. This means that at times competing priorities can impact on the efficiency and effectiveness of the system. For example, Forensic and Scientific Services is a business unit within the Department of Health and as such, competes with many other divisions for funding.

A 2005 Ministerial Taskforce's report on the role and function of Forensic and Scientific Services recommended that an independent entity be established based on best practice models in other jurisdictions such as New Zealand and the United Kingdom. Victoria has also established a dedicated statutory body (the Victorian Institute of Forensic Medicine) to deliver forensic medical services to the coronial and justice systems, separate from the Department of Health. The separate entity model acknowledges the difference in priorities and needs of medical services for court outcomes to those intended for health outcomes. It provides a clear delineation for governance, resourcing and control of funding.

Since 2003, the Department of Justice and Attorney-General has had an interdepartmental working group to review and discuss statewide policy and operational issues for Queensland's coronial system. But it has no terms of reference, lacks purpose, and has not delivered system improvements.

The costs of delivering coronial services are not well known. This is because the costs are spread across the contributing agencies and are not captured well by the agencies. Even when agencies know what the costs are, they are not necessarily managing them well.

For example, the Department of Justice and Attorney-General needs to tighten its approval process for funeral assistance applications. Currently, court registry staff approve applications for assistance with funding funerals, but at times they do this without performing an adequate assessment of the deceased's estate. (This includes checking if the deceased has, for example, superannuation, a house, and bank accounts.) As such, the Coroners Court of Queensland is paying money to some families that do not require funeral assistance. It has also been unsuccessful in recovering outstanding money, in part because it is constrained by the *Burials Assistance Act 1965*.

Coronial processes and practices

The number of deaths reported to the coroner has been increasing since 2011–12, but because agencies have improved their triage practices, they have reduced the number of reported deaths proceeding to a full coronial investigation. Triage is the process of sorting cases into categories (such as reportable and non-reportable deaths) that reflect whether further investigation is required. It also determines the extent of investigation needed (for example, the type of autopsy: external examination, partial autopsy, or full internal autopsy).

Various individuals from each of the agencies contribute to this triage process, including the Coroners Court of Queensland's coronial registrar and the Forensic and Scientific Services' duty pathologist, forensic medical officers, counsellors and coronial nurses. But this work is, to some extent, uncoordinated, and agencies do not assess all deaths reported to the coroner to ensure they're reportable. The agencies need to implement a more coordinated and systematic statewide triage process if they are to realise efficiencies.

They also need to have an effective case management practice to ensure an investigation is finalised in a timely manner, while ensuring it is conducted in an independent and robust manner. No one agency is accountable for managing a coronial investigation from start to finish. The agencies' case management practices vary and tend to be reactive rather than proactive.

There are other aspects of Queensland's coronial process that are potentially inefficient. For example, there is no requirement for a pathologist or coronial nurse to undertake a preliminary investigation when a death is reported. (A preliminary investigation can involve reviewing medical records or obtaining a computed tomography (CT) scan.)

As a result, coroners sometimes have limited information available to them to inform their decisions about whether an autopsy is required, the type needed (external, partial or full autopsy) and the most appropriate location for the autopsy. This may result in unnecessary investigations and potentially invasive autopsies. In other jurisdictions, coroners have CT scans, blood samples, and toxicology results provided to them as input to their decisions.

Coronial system performance

Excessive delays and a declining clearance rate are leading to a growing backlog of coronial investigations. This indicates that Queensland's coronial system is under stress. The state coroner has reported these delays in successive annual reports since 2014–15. The percentage of coronial cases in Queensland that are 24 months or older has increased from seven per cent in 2011–12 to 16 per cent in 2017–18. This excludes coronial cases delayed due to criminal proceedings.

The Commonwealth Government's Report on Government Services (which has data up to 2016–17) reports that since 2011–12 Victoria has reduced its backlog, despite having slightly higher numbers of reported deaths. In 2016–17, 10 per cent of their coronial cases were 24 months or older, compared to Queensland's 16 per cent. Excessive delays and a declining clearance rate reflect a coronial system that is underperforming.

Government undertakers

The Coroners Court of Queensland is responsible for the ongoing management of government undertakers. Although it documents the performance expectations for government undertakers in their contracts, it does not actively monitor their performance. As such the performance of some government undertakers is variable and there are instances of inappropriate conduct being reported. These instances are small when compared to the overall number of transportation services provided over this period. But they reflect breaches in performance and can have negative impacts on families.

Informing and supporting bereaved families

Despite the intent of the Act to support families during a coronial investigation and the best efforts of those that work within the coronial system, the communication and support provided to families is inadequate. The lack of clearly defined leadership and accountability across Queensland's coronial system, inadequate case management practices, and a lack of integration between agencies' systems contribute to this breakdown.

We found that the communication provided to families at the beginning of a coronial investigation is sufficient, but agencies do not provide adequate support to families throughout the investigation. In some instances, agencies have provided families with no additional communication despite the coronial investigation taking more than four years to finalise. The lack of dedicated case managers with the appropriate experience, training and authority, has at times meant families have received inconsistent or inadequate information during an investigation.

The Queensland Police Service and the Coroners Court of Queensland refer families to the Forensic and Scientific Services' coronial counsellors at the beginning of a coronial investigation. However, there are only five counsellors, and they often only provide information and support to families at the beginning of a coronial investigation. Similarly, witnesses at inquests can often require support. While agencies provide witnesses with some support it is limited. As a result, the agencies have, at times, overlooked the needs of some families and witnesses. The agencies require a more coordinated approach to ensure families and witnesses receive adequate support throughout a coronial investigation, including counselling services.

Audit conclusions

Queensland's coronial system is under stress and is not effectively and efficiently supporting coroners or families. If left unaddressed, structural and system issues, will further erode its ability to provide services beyond the short-term.

Senior people across the system described to us a system that is failing. The coronial system relies on the dedication of staff and good will amongst agencies but lacks system-wide cohesion, with no agency having responsibility for leadership, accountability, planning, and reporting across the system.

This is contributing to:

- ineffective planning
- insufficient and inadequate resourcing and funding
- inadequate case management practices
- a lack of integration between agencies' priorities and systems.

For years, agencies have made efforts to address specific issues that prevent them from effectively or efficiently delivering aspects of coronial services. Some of their efforts have provided efficiencies, such as the appointment of a coronial registrar to filter some non-reportable deaths from the system and divert some reportable deaths from unnecessary autopsy and a full coronial investigation. Overall, however, agencies' efforts have been fragmented, have lacked purpose and coordination, and have failed to address critical system-wide issues. Many of the system issues identified in a 2002 review of the previous Act (the *Coroners Act 1958*) still exist, including:

- a lack of coordination and accountability
- regional disparity
- a lack of support and information to families.

As a result, the backlog of outstanding coronial cases 24 months or older continues to increase, investigations are being delayed, and some families are poorly informed.

To improve coronial services now and into the future, agencies must take a more integrated approach to managing and operating the system. This can best be achieved by working together to address a number of significant, system-wide structural and process issues. Only then are they likely to improve their support to coroners and families.

Recommendations

Department of Justice and Attorney-General, Department of Health, Queensland Police Service, and the Department of Premier and Cabinet

We recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners:

1. establish effective governance arrangements across the coronial system by:
    - creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist
    - more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services
    - establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.
2. evaluate the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems.

Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service

We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners:

3. improve the systems and legislation supporting coronial service delivery by:
    - identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports
    - reviewing the *Coroners Act 2003* to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process
    - reviewing the *Burials Assistance Act 1965* and the burials assistance scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.

4. improve processes and practices across the coronial system by:
    - ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported case managers to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators
    - ensuring there is a coordinated, statewide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy
    - establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process
    - ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.
5. assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased.

Department of Justice and Attorney-General

We recommend the Department of Justice and Attorney-General:

6. implements a strategy and timeframe to address the growing backlog of outstanding coronial cases. In developing and implementing this strategy it should collaborate with the Department of Health, Queensland Police Service, and coroners
7. improve the performance monitoring and management of government undertakers. This should include taking proactive action to address underperformance where necessary in accordance with the existing standing offer arrangements.

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